



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  OXMED INC PO BOX 972557 DALLAS TX 75397-2557	MFDR Tracking #: M4-03-8922-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "We feel that we are due the total amount billed for the equipment provided to this patient. The carrier has incorrectly reviewed this claim stating the claim was paid at a fair and reasonable rate and suggested the we the provider provide an invoice in order to receive payment in full for the items provided to this injured worker. Obviously the carrier does not understand that the provider 'Is not required to **Submit** an invoice and reimbursement is to be based on Fair and Reasonable and not on the invoice price. We are requesting full Payment on the unpaid claims with accruing interest until paid in full by the carrier for the above listed dates of service."

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought \$5,056.92

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "As a result of this review of the additional documentation submitted further payment has been recommended in the amount of \$3,908.49 towards the amount in dispute of \$5,056.92. Please refer to the attached Explanation of Benefits Reports and Re-evaluations."

**Principal Documentation:**

1. Response Package

### PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
2/14/2003	E0244	\$36.00 - \$39.69 = \$0.00.	\$63.31	\$0.00
	E0930	Not Applicable	\$14.12	\$0.00
	E1399	Not Applicable	\$16.80	\$0.00
2/18/2003	E0245	The requestor billed \$110.00 for HCPCS code E0245 rendered on 2/14/2003. Less the amount of \$93.50 previously paid by the carrier leaves \$16.50. The respondent made an additional payment of \$16.50 for a total of \$110.00.	\$74.10 Incorrect disputed amount for service <\$16.50>	\$0.00
	E1399	Not Applicable	\$11.25	\$0.00
	E1399	Not Applicable	\$23.25	\$0.00

5/8/2003	L0180	Not Applicable	\$400.00	\$0.00
	L0172	Not Applicable	\$151.15	\$0.00
	L0120	Not Applicable	\$33.05	\$0.00
	E0143	After request was submitted the respondent made an additional payment of \$76.59, remaining in dispute \$0.00	\$76.59 <\$76.59>	\$0.00
	E1399	Not Applicable	199.05	\$0.00
5/22/2003	E0215	\$80.75 - \$80.75 = \$0.00	\$44.25	\$0.00
	E0748	Not Applicable	\$3,950.00 <\$3,200.00> \$750.00	\$0.00
<b>Total Due:</b>				<b>\$0.00</b>

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. This request for medical fee dispute resolution was received by the Division on July 28, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 31, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires services not identified in a fee guideline shall be reimbursed at fair and reasonable.
3. Texas Labor Code §413.011, requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 3/29/2003 for date of service 2/14/2003

- 426-Reimbursed to fair and reasonable.
- M-Reduced to fair and reasonable.

Explanation of benefits dated 3/25/2003 for date of service 2/18/2003

- 710-This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit.
- N-Not documented.

Explanation of benefits dated 5/29/2003 for date of service 5/8/2003

- 426-Reimbursed to fair and reasonable.
- M-Reduced to fair and reasonable.
- N-Not documented.
- 253-In order to review this charge we will need a copy of the invoice.
- 360-Allowance for this procedure was made at the 'fair and reasonable' amount for this geographical area.

Explanation of benefits dated 6/10/2003 for date of service 5/22/2003

- 360-Allowance for this procedure was made at the 'fair and reasonable' amount for this geographical area.
- M-Reduced to fair and reasonable.

- 426-Reimbursed to fair and reasonable.

Explanation of benefits dated 7/15/2003 for date of service 5/22/2003

- 253-In order to review this charge we will need a copy of the invoice.
- 360-Allowance for this procedure was made at the 'fair and reasonable' amount for this geographical area.
- M-Reduced to fair and reasonable.

Explanation of benefits dated 9/4/2003 for dates of service 2/14/2003 through 5/22/2003

- 426-Reimbursed to fair and reasonable.
- M-Reduced to fair and reasonable.
- 420-Supplemental payment.
- S-Supplemental payment.
- Based on the clarifying and/or additional information now submitted, we are recommending further payment be made for the above noted procedure code.
- In order to reconsider the submitted charges for additional payment, a copy of the invoice is required. In view of this we are unable to recommend an additional allowance at this time.
- 253-In order to review this charge we will need a copy of the invoice.
- 360-Allowance for this procedure was made at the 'fair and reasonable' amount for this geographical area.
- N-Not documented.

### **Issues**

1. Was the dispute filed in the form, format and manner prescribed by Division rule at 28 TAC §133.307?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division notes that the requestor has listed on the *Table of Disputed Services* HCPCS code E0245 for a billed amount of \$494.00 for date of service 2/18/2003. A review of the submitted medical bill for date of service 2/18/2003, does not list HCPCS code E0245. Instead, the requestor billed HCPCS code E0236 for \$494.000. The Division finds that the requestor billed HCPCS code E0245 on 2/14/2003 for \$110.00. Therefore, the Division concludes HCPCS code E0245 was billed on 2/14/2003 for \$110.00.

Furthermore, the requestor incorrectly noted on the *Table of Disputed Services*, disputed date of service 5/22/2003 for HCPCS code E0215. Per the submitted medical bill and EOBs, this service was rendered on 5/8/2003. The Division concludes that HCPCS code E0125 was rendered on 5/8/2003.

Therefore, the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(C).

2. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d), requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE IV, titled Nonlisted Items and Documentation of Procedure states that "This document does not contain a specific MAR for DME items. The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and

carrier, or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. Use the miscellaneous HCPCS code, E1399, when no other HCPCS code is present for the DME or supplies provided to the injured worker. When using E1399, a description of the unlisted equipment/supply is required.”

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated between the provider and carrier for the disputed HCPCS codes; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate for the item described per Division rule at 28 TAC §134.201 DME GROUND RULE IV.

HCPCS code E1399 is described as “Durable medical equipment, miscellaneous.”

On 2/14/2003, the requestor noted on the medical bill that HCPCS code E1399 was for a shower head/hose extensions; therefore, the requestor submitted a descriptor in accordance with Division rule at 28 TAC §134.201 DME GROUND RULE (IV).

On 2/18/2003, the requestor noted on the medical bill that HCPCS code E1399 was for a “Cold therapy cooler wrap” and for a “Water circulating pad”; therefore, the requestor submitted a descriptor in accordance with Division rule at 28 TAC §134.201 DME GROUND RULE (IV).

On 5/8/2003, the requestor noted on the medical bill that HCPCS code E1399 was for a “Pillow-Tempur pressure relief”; therefore, the requestor submitted a descriptor in accordance with Division rule at 28 TAC §134.201 DME GROUND RULE (IV).

Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that “The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the ‘D’ codes in the 1991 Medical Fee Guideline.” The Division finds that HCPCS code E1399 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for these items. Therefore, reimbursement for these items is subject to the provisions of Texas Workers’ Compensation Act §413.011 and Division rule at 28 TAC §134.1.

HCPCS code E0244 is described as “Raised toilet seat.” Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that “The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the ‘D’ codes in the 1991 Medical Fee Guideline.” The Division finds that HCPCS code E0244 does not have a MAR established in the 1996 MFG. A review of the 1991 MFG finds a comparable code for HCPCS code E0244 in “D” code “D0233-Toilet seat, raised, 1-piece plastic.” Per the 1991 MFG, “D” code D0233 has a purchase price of \$36.00.

HCPCS code E0930 is described as “Fracture frame, freestanding, includes weights.” Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that “The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the ‘D’ codes in the 1991 Medical Fee Guideline.” The Division finds that HCPCS code E0930 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for this item. Therefore, reimbursement for this item is subject to the provisions of Texas Workers’ Compensation Act §413.011 and Division rule at 28 TAC §134.1.

HCPCS code E0245 is described as “Tub stool or bench.” Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that “The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the ‘D’ codes in the 1991 Medical Fee Guideline.” The Division finds that HCPCS code E0245 does not have a MAR established in the 1996 MFG. A review of the 1991 MFG finds a comparable code for HCPCS code E0245 in “D” code “D0241-Tub, stool or bench, basic plastic.” Per the 1991 MFG, “D” code D0241 has a purchase price of \$117.00.

HCPCS code L0180 is described as “Cervical, multiple post collar, occipital/mandibular supports, adjustable.” Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that “The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider’s usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the ‘D’ codes in the 1991 Medical Fee Guideline.” The Division finds that HCPCS code L0180 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for this item. Therefore, reimbursement

for this item is subject to the provisions of Texas Workers' Compensation Act §413.011 and Division rule at 28 TAC §134.1.

HCPCS code L0172 is described as "Cervical, collar, semi-rigid thermoplastic foam, 2 piece." Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." The Division finds that HCPCS code L0172 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for this item. Therefore, reimbursement for this item is subject to the provisions of Texas Workers' Compensation Act §413.011 and Division rule at 28 TAC §134.1.

HCPCS code L0120 is described as "Cervical, flexible, nonadjustable (foam collar)." Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." The Division finds that HCPCS code L0120 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for this item. Therefore, reimbursement for this item is subject to the provisions of Texas Workers' Compensation Act §413.011 and Division rule at 28 TAC §134.1.

HCPCS code E0143 is described as "Folding walker, wheeled, without seat." The requestor is seeking dispute resolution for an additional payment of \$76.59. After the dispute was filed with the Division, the respondent made an additional payment for the disputed amount of \$76.59. Therefore, the dispute for HCPCS code E0143 is resolved.

HCPCS code E0215 is described as "Electric heat pad, moist." Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." The Division finds that HCPCS code E0215 does not have a MAR established in the 1996 MFG. A review of the 1991 MFG finds a comparable code for HCPCS code E0215 in "D" code "D0341-Heating pad, moist, electric." Per the 1991 MFG, "D" code D0341 has a purchase price of \$80.75.

HCPCS code E0748 is described as "Osteogenesis stimulator (non-invasive)." Division rule at 28 TAC §134.201, DME GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." The Division finds that HCPCS code E0748 does not have a MAR established in the 1996 MFG. In addition, a comparable HCPCS code could not be identified in the 1991 MFG for this item. The requestor is seeking dispute resolution for an additional payment of \$3950.00 for this item. After the dispute was filed with the Division, the respondent made an additional payment of \$3,200.00; therefore \$750.00 remains in dispute for this item. Reimbursement for this item is subject to the provisions of Texas Workers' Compensation Act §413.011 and Division rule at 28 TAC §134.1.

3. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's rationale for increased reimbursement from the Table of Disputed Services states "We feel that we are due the total amount billed for the equipment provided to this patient. The carrier has incorrectly reviewed this claim stating the claim was paid at a fair and reasonable rate and suggested the we the provider provide an invoice in order to receive payment in full for the items provided to this injured worker. Obviously the carrier does not understand that the provider 'Is not required to **Submit** an invoice and reimbursement is to be based on Fair and Reasonable and not on the invoice price. We are requesting full Payment on the unpaid claims with **accruing interest** until paid in full by the carrier for the above listed dates of service."
- In support of the requested reimbursement, the requestor submitted redacted EOBs for services that are similar to the services in dispute. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOBs, was typical for the services in dispute.
- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of

payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for reimbursement is not supported for HCPCS codes E1399, E0930, L0180, L0172, L0120 and E0748. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for HCPCS codes E1399, E0930, L0180, L0172, L0120 and E0748. Additional payment cannot be recommended.

Reimbursement will therefore be calculated as follows for HCPCS codes E0244, E0245 and E0215:

- HCPCS code E0244 - Raised toilet seat. The fair and reasonable amount for this DME item is \$36.00, less the amount of \$39.69 previously paid by the carrier leaves an amount due of \$0.00.
- HCPCS code E0245 - Tub stool or bench. The fair and reasonable amount for this DME item is \$117.00. The requestor is seeking reimbursement of \$110.00. Per the submitted EOBs, the requestor originally paid \$93.50. After the dispute was received in the Division, the respondent made an additional payment of \$16.50, for a total of \$110.00. As a result the amount due is \$0.00.
- HCPCS code E0215 - Electric heat pad, moist. The fair and reasonable amount for this DME item is \$80.75, less the amount of \$80.75 previously paid by the carrier leaves an amount due of \$0.00.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(C) and §133.307(g)(3)(D). The Division further concludes that for the reasons stated above, the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services involved in this dispute.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

**July 26, 2010**

\_\_\_\_\_  
Date

### **PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**